

CLAIM AGAINST DEPARTMENT OF TRANSPORTATION FOR AMOUNTS \$5,000 OR LESS

LD-0274 (REV 1/2003)

PERSONAL INFORMATION NOTICE

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code Sections 1798, et seq.), notice is hereby given for the request of personal information by this form. The requested personal information is voluntary. The principal purpose of the voluntary information is to facilitate the processing of this form. The failure to provide all or any part of the requested information may delay processing of this form. No disclosure of personal information will be made unless permissible under Article 6, Section 1798.24 of the IPA of 1977. Each individual has the right upon request and proper identification, to inspect all personal information in any record maintained on the individual by an identifying particular. Direct any inquiries on information maintenance to your IPA Officer.

This form is to be used when filing a claim against the Department of Transportation as provided in Government Code Section 935.7.

PLEASE: \$ print or use a typewriter when filling out form.

\$ sign and date claim form.

(UNSIGNED AND UNDATED FORMS WILL NOT BE ACCEPTED)

			STATE USE ONLY
1. NAME: LAST	FIRST	MIDDLE	FILE NUMBER
HOME ADDRESS		BUSINESS PHONE	HOME PHONE
CITY		STATE	ZIP CODE
2. PUT A SPECIFIC TIME AND DATE WHEN THE DAMAGE FIRST OCCURED		TIME OF INCIDENT <input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INCIDENT
3. STATE THE LOCATION OF THE INCIDENT WITHIN ONE-HALF MILE (CITY, COUNTY, HIGHWAY, NEAREST OFF-RAMP, CROSS STREET OR, POSTMILE).			
4. EXPLAIN HOW THE INJURY OR DAMAGE OCCURRED			
WHAT PARTICULAR ACT OR OMISSION ON THE PART OF CALTRANS OR ITS CONTRACTOR CAUSED THE INJURY OR DAMAGE?			
WHAT INJURY OR DAMAGE DO YOU CLAIM RESULTED?			
WHAT IS THE DOLLAR AMOUNT OF YOUR CLAIM FOR DAMAGES? (SUBMIT TWO ESTIMATES OR PAID RECEIPTS)			
\$			
5. INSURANCE INFORMATION IS REQUIRED		NAME OF INSURER	
ARE YOU THE REGISTERED OWNER? <input type="checkbox"/> YES <input type="checkbox"/> NO		HAVE YOU SUBMITTED A CLAIM TO YOUR INSURANCE CARRIER? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IN YES, WERE YOU PAID? <input type="checkbox"/> YES <input type="checkbox"/> NO		FOR WHAT AMOUNT? \$	
VEHICLE INFORMATION			
MAKE OF VEHICLE		YEAR	LICENSE NO.
I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT THE FOREGOING FACTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.			
SIGNATURE OF CLAIMANT			DATE

REVERSE SIDE FOR STATE USE AND FILING INFORMATION ON CLAIMS